NEW Electronic Submission

As of December 1, 2007, the Canadian Journal of Neurological Sciences went to an Electronic Submission process. ALL manuscript submissions will be handled by an On-Line tracking system. Go to www.cjns.org and click on SUBMIT YOUR MANUSCRIPT and follow the instructions.

(we will no longer accept paper/disc submissions)

The manuscript submission process is broken into a series of five screens that gather detailed information about your manuscript and allow you to upload the pertinent files. The sequence of screens are as follows:

1. A long form asking for author information, title, abstract, and file quantities.
2. A screen asking for the actual file locations on your computer (via an open file dialog). After completing this screen, your files will be uploaded to our server.
3. A screen requesting the order files should appear in the system-generated merged PDF.
4. A completion screen that will provide you with a specific manuscript number for your manuscript.
5. An approval screen that will allow you to verify that your manuscript was uploaded and converted correctly. You are allowed to replace and delete files, as well as withdraw the manuscript, on this page.

Before submitting a manuscript, please gather the following information:

- All Authors
  - First Names, Middle Names/Initials, Last Names
  - Institutions
  - Departments
  - Phone and Fax Numbers
  - Street Addresses
  - E-mail Addresses
- Title and Running Title (you may copy and paste these from your manuscript)
- Abstract (you may copy and paste this from your manuscript)
- Key words
- Manuscript files in Word, WordPerfect, or Text formats
- Figures/Images in TIF, EPS, PDF, or JPG formats
- Tables in XLS or DOC formats

Kind of figure/File mode/Ideal resolution/ Minimum resolution

Line Bitmap	1200 ppi(ideal) 600 ppi(min)
Color photo CMYK	350 ppi(ideal) 200 ppi(min)
B/W halftone (black and white photo) Grayscale	350 ppi(ideal) 200 ppi(min)
Line/halftone combination	**Grayscale** 600 ppi(ideal) 200 ppi(min)

Uniform Requirements for Manuscripts Submitted to Biomedical Journals: Writing and Editing for Biomedical Publication International Committee of Medical Journal Editors

For detailed instructions regarding style and layout refer to "Uniform requirements for manuscripts submitted to biomedical journals". Copies of this document may be obtained on the website http://www.icmje.org. Articles should be submitted under conventional headings of introduction, methods and materials, results, discussion, but other headings will be considered if more suitable. For Uniform Requirements for Sample References go to http://www.nlm.nih.gov/bsd/uniform_requirements.html.

After the manuscript is submitted, you will be asked to select the order you would like the files to be displayed in a merged PDF file that the system will create for you. Next, you will be directed to a page that will allow you to review your converted manuscript. If the conversion is not correct, you can replace or delete your manuscript files as necessary. You may also add additional files at this time. After you have reviewed the converted files, you will need to click on "Approve Converted Files." This link will have a red arrow next to it. Throughout the system, red arrows reflect pending action items that you should address.

Cover Letter

A cover letter is required and must state that the manuscript: has not been published elsewhere, except in abstract form is not under simultaneous consideration by another journal. Once a decision is made by the Editor on your manuscript, the Journal office will send you an Author Release form and a Conflict of Interest form if your manuscript has been accepted for revision.

Abstracts

Original Articles and Case Reports should be accompanied by an abstract of 250 words or less on a separate page, in either English or French. The Journal will provide translation to the other language if required. Abstracts should consist of four paragraphs headed: Background (or Objective), Methods, Results and Conclusions.

Acknowledgements

Acknowledgements, including recognition of financial support, should be typed on a separate page at the end of the text. The SI system (système international d'unités) should be used in reporting all laboratory data, even if originally reported in another system. Temperatures are reported in degrees celsius. English language text may use either British or American spelling, but should be consistent throughout.

References

References should be numbered in the order of their citation in the text. Those cited only in tables and legends for illustrations are numbered according to the sequence established by the first identification in the text of a particular table or illustration.

Titles of journals should be abbreviated according to the style used in Index Medicus. References should list the names of up to six authors; if there are more, cite the first SIX, then et al.

Provide the full title, year of publication, volume number and inclusive pagination for journal articles. Do not reference unpublished or "submitted" papers; these can be mentioned in the body of the text and authors must provide five copies of "submitted" manuscripts.

Avoid "personal communications" and, if necessary, include them in the body of the text, not among the references. Reference citations should not include unpublished presentations or other non-accessible material. Books or chapter references should also include the place of publication and the name of the publisher.

For Reference Guidelines
www.nlm.nih.gov/bsd/uniform_requirements.html

Examples of correct forms of reference:

Journals

Rose ME, Huerbin MB, Melick J, Marion DW, Palmer AM, Schiding JK, et al. Regulation of interstitial excitatory amino acid concentrations after cortical contusion injury. Brain Res. 2002;935(1-2):40-6.

Chapter in a book

Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in human solid tumors. In: Vogelstein B, Kinzler KW, editors. The genetic basis of human cancer. New York: McGraw-Hill; 2002. p. 93-113.

Tables

Type tables double-spaced on pages separate from the text. Provide a table number and title for each. Particular care should be taken in the preparation of tables to ensure that the data are presented clearly and concisely. Each column should have a short or abbreviated heading. Place explanatory matter in footnotes, not in the heading. Do not submit tables as photographs.

Review Articles

Review articles on selected topics are also published. They are usually invited, but unsolicited reviews will be considered. Review articles should be accompanied by an abstract of 150 words or less.

Brief Correspondence (formerly Peer Reviewed Letters)

Brief Correspondence articles to the Editor are published on various topics. The articles should be limited to approximately six double-spaced manuscript pages (2-3 Journal pages) and may include illustrations and tables.

Editor Correspondence

Correspondence to the Editor concerning matters arising in recent articles are welcome. Correspondence should be limited to two double-spaced pages and may include one illustration and a maximum of four references.

Neuroimaging Highlights

Neuroimaging highlights are selected by the editor-in-chief and neuroimaging highlight editors on the basis of two factors. The first is high quality "state of the art" imaging of a novel and uncommon (or common with an uncommon twist) neurological or neurosurgical disorder. The second factor is the clinical novelty of the case.

Neuroimaging highlights require a figure of several panels that clearly outlines all features of the relevant imaging. For example, for MR images this may require different cuts and sequences, etc. Combining more than one imaging modality strengthens the report. The report may also benefit from a single additional panel in a figure if it is directly relevant, e.g. a pathological image or patient image. The text should include a very brief discussion of the case history confined to the relevant history, pertinent abnormal findings, and clinical course with outcome. An additional one to two paragraphs should briefly describe the neuroimaging panels present, and very briefly review relevant aspects of the literature. Overall, the neuroimaging highlights should be 500 words or less, with no more than 10 references.

Images should be of the highest quality, submitted either as glossy prints or electronically as a tiff file at a minimum of 300 dpi and at a size large enough for the printed journal (i.e. not less than 2" wide).

Suitability for publication is judged by the neuroimaging highlight editors, the editor-in-chief and up to one additional external referee.

Reflections

Neuroimaging highlights are selected by the editor-in-chief and neuroimaging highlight editors on the

Permissions and Releases

Any non-original material (quotations, tables, figures) must be accompanied by written permission from the author and the copyright owner to reproduce the material in the Journal. Photographs of recognizable persons must be accompanied by a signed release from the legal guardian or patient authorizing publication.

Conflict of Interest

Authors who have non-scientific or non-academic gain, whether it be financial or other, from publishing their article are responsible for declaring it to the Editor. Any financial interest, research grant, material support, or consulting fee associated with the contents of the manuscript must be declared to the Editor. These guidelines apply to each author and their immediate families. Conflicts of interest are not necessarily wrong, nor do they necessarily change the scientific validity of research or opinion, but the Journal and readers should be aware of the conflict. If the Editor considers the conflict to compromise the validity of the paper, it will not be accepted for publication.

Authors, editorial staff and reviewers are asked to declare any relationship that would be considered as a conflict of interest whether or not they believe that a conflict actually exists. Information that the Journal receives about conflict or potential conflict will be kept confidential unless the Editor or Associate Editor considers it to be important to readers. Such conflicts will be published in the author credits or as a footnote to the paper, with knowledge of the authors.

Getting Help

If you need additional help, you can click on the help signs spread throughout the system. A help dialog will pop up with context-sensitive help.

Manuscript Status

After you approve your manuscript, you are finished with the submission process. You can access the status of your manuscript at any time via:

1. Logging into the system with your password
2. Clicking on the link represented by your manuscript tracking number and abbreviated title
3. Clicking on the "Check Status" link at the bottom of the displayed page

   This procedure will display detailed tracking information about where your manuscript is in the submission/peer-review process.

Starting

The manuscript submission process starts by pressing the "Submit Manuscript" link on your "Home" page (www.cjns.org). Please make sure you have gathered all the required manuscript information listed above BEFORE starting the submission process.

INDEX

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

CALENDAR OF EVENTS

February 16-17, 2009
Tel Aviv, Israel
5th Annual Update Symposium on Clinical Neurology and Neurophysiology
For more information, please visit our website at: www.neurophysiology-symposium.com

March 11-14, 2009
Victoria, British Columbia, Canada
3rd International Conference on Fetal Alcohol Spectrum Disorder Integrating Research, Policy and Promising Practice Around the World: A Catalyst for Change
Register before the Early Bird Deadline of January 12, 2009 to take advantage of the reduced rate. Telephone (604) 822-7524 or Toll-free within BC: 1-877-328-7744; Fax: (604) 822-4835 OR Via E-Mail: jpad@interchange.ubc.ca or go to our website at www.peopleware.net/index.cfm?siteCode=1268.

March 11-15, 2009
Prague, Czech Republic
9th International Conference - Alzheimer's & Parkinson's Diseases: Advances, Concepts & New Challenges
For more information or to register, please visit www.kenes.com/adpd

March 27-31, 2009
Marseille, France
Marseille Neurosurgery 2009 Joint Annual Meeting (EANS-SFNC)
For information, please visit our website at: www.kenes.com/eans-sfnc.

April 2-4, 2009
Washington, DC, USA
2nd International Conference on Psychogenic Movement Disorders and Other Conversion Disorders
For more information, please visit our website at: www.movementdisorders.org/education/pmd

April 15-18, 2009
Rotterdam, The Netherlands
9th European Skull Base Society Meeting
For more information, please visit our website at: www.esbs2009.eu.

April 25-28, 2009
Rome, Italy
XI International Facial Nerve Symposium
For more information go to www.facialnerve2009.org.

April 25 - May 2, 2009
Seattle, Washington, USA
AAN Annual Meeting
For information go to: www.aan.com

May 7-9, 2009
Vancouver, British Columbia, Canada
International Vocational Outcomes in Traumatic Brain Injury Conference 2009
For information go to: www.tbicvancouver.com

May 10-13, 2009
Ottawa, Ontario, Canada
2nd Annual Canadian Network for Innovation in Education (CNIE) International Conference 2009
For more information please visit the 2009 International Conference website at www.learningconference.ca.

June 9-12, 2009
Halifax, Nova Scotia, Canada
44th Annual Congress of the Canadian Neurological Sciences Federation
For more information go to: www.cnsfederation.org or contact the secretariat office at (403) 229-9544.

June 10-13, 2009
Daegu, Korea
10th Asian & Oceanian Congress of Child Neurology
For registration, hotel information and other information go to www.aoccn2009.com.

July 7-10, 2009
Toronto, Ontario, Canada
SickKids Centre for Brain & Behaviour 1st Annual International Symposium
Visit www.sickkids.ca/learninginstitute or email li.conferences@sickkids.ca.

August 27-30, 2009
Munich, Germany
1st International Congress on Clinical Neuroepidemiology
For information about our Congress, please go to our website: www.neuro2009.com.

August 30-September 4, 2009
Boston, Massachusetts, USA
XIV Congress of the World Federation of Neurosurgical Societies (WFNS)
For more information or to register, please visit www.AANS.org/wfns2009 or email wfns2009@aans.org

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

PrLYRICA® PREGABALIN

PRESCRIBING SUMMARY

PATIENT SELECTION CRITERIA

THERAPEUTIC CLASSIFICATION: Analgesic Agent

INDICATIONS AND CLINICAL USE

LYRICA is indicated for the management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia in adult patients.

LYRICA may be useful in the management of central neuropathic pain in adult patients for which it has been issued marketing authorization with conditions to reflect the promising nature of the clinical evidence and the need for a confirmatory study to verify its clinical benefit. Patients should be advised of the nature of the authorization.

CONTRAINDICATIONS: Patients who are hypersensitive to pregabalin or to any ingredient in the formulation or component of the container.

SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Tumorigenic Potential: In standard preclinical in vivo lifetime carcinogenicity studies of pregabalin, a high incidence of hemangiosarcoma was identified in two different strains of mice. The clinical significance of this finding is uncertain. Clinical experience during pregabalin's premarketing development provides no direct means to assess its potential for inducing tumors in humans.

Ophthalmological Effects: In controlled studies, pregabalin treatment was associated with vision-related adverse events such as blurred vision (amblyopia) (6% pregabalin and 2% placebo) and diplopia (2% pregabalin and 0.5% placebo). Approximately 1% of pregabalin-treated patients discontinued treatment due to vision-related adverse events (primarily blurred vision). Of the patients who did not withdraw, the blurred vision resolved with continued dosing in approximately half of the cases (see Product Monograph, **Post-Marketing Adverse Drug Reactions**).

Patients should be informed that if changes in vision occur, they should notify their physician.

Peripheral Edema: In controlled clinical trials pregabalin treatment caused peripheral edema in 6% of patients (336/5508) compared with 2% of patients (42/2,384) in the placebo group. In these studies, 0.5% (28/5508) of pregabalin patients and 0.2% (4/2,384) of placebo patients withdrew due to peripheral edema (see Product Monograph, **ADVERSE REACTIONS, Peripheral Edema**).

In controlled clinical trials of up to 13 weeks in duration of patients without clinically significant heart or peripheral vascular disease, there was no apparent association between peripheral edema and cardiovascular complications such as hypertension or congestive heart failure. In the same trials, peripheral edema was not associated with laboratory changes suggestive of deterioration in renal or hepatic function.

Higher frequencies of weight gain and peripheral edema were observed in patients taking both LYRICA (pregabalin) and a thiazolidinedione antidiabetic agent compared to patients taking either drug alone.

As the thiazolidinedione class of antidiabetic drugs can cause weight gain and/or fluid retention, possibly exacerbating or leading to heart failure, care should be taken when co administering LYRICA and these agents.

Congestive Heart Failure: In controlled clinical studies, events of congestive heart failure were reported at an infrequent rate (between 0.1% and 1%; see Product Monograph, **ADVERSE REACTIONS, Less Common Clinical Trial Adverse Reactions**).

There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin (see Product Monograph, **ADVERSE REACTIONS, Post-marketing Adverse Drug Reactions**). These reactions are mostly seen in elderly cardiovascular compromised patients during pregabalin treatment for a neuropathic pain indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction.

Weight Gain: Pregabalin treatment was associated with weight gain. In pregabalin controlled clinical trials of up to 13 weeks, a gain of 7% or more over baseline weight was observed in 8% of pregabalin treated patients and 2% of placebo-treated patients. Few patients treated with pregabalin (0.2%) withdrew from controlled trials due to weight gain (see Product Monograph, **ADVERSE REACTIONS, Weight Gain**). Pregabalin-associated weight gain was related to dose and duration of exposure, but did not appear to be associated with baseline BMI, gender, or age. Weight gain was not limited to patients with edema (see Product Monograph, **WARNINGS AND PRECAUTIONS, Peripheral Edema**).

Although weight gain was not associated with clinically important changes in blood pressure in short-term controlled studies, the long-term cardiovascular effects of pregabalin-associated weight gain are unknown.

While the effects of pregabalin-associated weight gain on glycemic control have not been systematically assessed, in controlled and longer-term open label clinical trials with diabetic patients, pregabalin treatment did not appear to be associated with loss of glycemic control (as measured by HbA_{1C}).

Dizziness and Somnolence: In controlled neuropathic pain studies, pregabalin caused dizziness in 23% of patients (424/1,831) compared to 7% in placebo (58/857). Somnolence was experienced by 14% (256/1,831) and 4% (33/857) of the patients treated with pregabalin and placebo, respectively. These events begin shortly after the initiation of therapy and generally occur more frequently at higher doses.

Abrupt or Rapid Discontinuation: Following abrupt or rapid discontinuation of pregabalin, some patients reported symptoms including insomnia, nausea, headache, and diarrhea. Pregabalin should be tapered gradually over a minimum of one week rather than discontinued abruptly (see Product Monograph, **ADVERSE REACTIONS, Adverse Events Following Abrupt or Rapid Discontinuation**).

ADVERSE REACTIONS

Clinical Trial Adverse Drug Reactions: *Most Common Adverse Events in All Pre-marketing Controlled Clinical Studies of Peripheral Neuropathic Pain*: The most commonly observed adverse events (≥5% and twice the rate of that seen in placebo) in pregabalin-treated patients were: dizziness, somnolence, peripheral edema, and dry mouth. Adverse events were usually mild to moderate in intensity.

Adverse Events From a Controlled Clinical Study in Central Neuropathic Pain Associated With Spinal Cord Injury: The most commonly observed treatment-related adverse events (≥5% and twice the rate of that seen in placebo) in pregabalin-treated patients were: somnolence, dizziness, asthenia, dry mouth, edema, myasthenia, constipation, thinking abnormal, amblyopia, and amnesia. Adverse events were usually mild to moderate in intensity.

To monitor drug safety, Health Canada collects information on serious and unexpected effects of drugs. If you suspect you have had a serious or unexpected reaction to this drug you may notify Health Canada by telephone: 1-866-234-2345.

ADMINISTRATION

Dosing Considerations

Patients with Impaired Renal Function: **Pregabalin is primarily eliminated from the systemic circulation by renal excretion as unchanged drug. In patients with a medical history of significant renal insufficiency, daily dosages should be reduced accordingly (see Table in Supplemental Product Information).**

Adults:

Neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia: The recommended starting dose for LYRICA is 150 mg/day, given in two or three divided doses (75 mg BID or 50 mg TID), with or without food in patients with a creatinine clearance rate of at least 60 mL/min. Efficacy of LYRICA has been demonstrated within the first week. Based on individual patient response and tolerability, the dose may be increased to 150 mg BID (300 mg/day) after one week.

For patients who experience significant and ongoing pain and can tolerate pregabalin 300 mg/day well, maximum daily dose of 600 mg (300 mg BID) can be used. However, in clinical trials, LYRICA 600 mg/day did not provide additional significant efficacy and patients treated with this dose experienced markedly higher rates of adverse events and discontinued the trial more frequently.

Central neuropathic pain: The recommended starting dose for LYRICA is 150 mg/day, given in two divided doses (75 mg BID), with or without food in patients with a creatinine clearance rate of at least 60 mL/min. Efficacy of LYRICA has been demonstrated within the first week. Based on individual patient response and

tolerability, the dose may be increased to 150 mg BID (300 mg/day) after one week.

For patients who experience significant and ongoing pain and can tolerate pregabalin 300 mg/day well, a maximum daily dose of 600 mg (300 mg twice a day, BID) may be considered.

Administration: LYRICA is given orally with or without food.

Supplemental Product Information

Special Populations: ***Geriatrics (≥65 years of age):*** Pregabalin oral clearance tended to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with age-related decreases in creatinine clearance. Reduction of pregabalin dose may be required in patients who have age-related compromised renal function (see Product Monograph, **WARNINGS AND PRECAUTIONS**, **Geriatrics >65 years of age**).

Pregnant Women: There are no adequate and well-controlled studies in pregnant women. Pregabalin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labour and Delivery: The effects of pregabalin on labour and delivery in pregnant women are unknown.

Nursing Women: It is not known if pregabalin is excreted in human breast milk; however, it is present in the milk of rats. Because of the potential for adverse reactions in nursing infants from pregabalin, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatrics (<18 years of age): The safety and efficacy of pregabalin in pediatric patients (<18 years of age) have not been established and its use in this patient population is not recommended (see Product Monograph, **WARNINGS AND PRECAUTIONS**, **Pediatrics**).

WARNINGS AND PRECAUTIONS: See the Product Monograph for further information on the following: tumorigenic potential, ophthalmological effects, peripheral edema, congestive heart failure, weight gain, dizziness and somnolence, sexual function/reproduction, and special populations.

DRUG INTERACTIONS

Overview: Since pregabalin is predominately excreted unchanged in the urine, undergoes negligible metabolism in humans (<2% of a dose recovered in urine as metabolites), does not inhibit drug metabolism in vitro, and is not bound to plasma proteins, LYRICA (pregabalin) is unlikely to produce, or be subject to, pharmacokinetic interactions.

Drug Abuse and Dependence/Liability: Pregabalin is not known to be active at receptor sites associated with drugs of abuse. As with any CNS active drug, physicians should carefully evaluate patients for history of drug abuse and observe them for signs of LYRICA misuse or abuse (e.g., development of tolerance, dose escalation, drug-seeking behaviour).

ADMINISTRATION

Dosage Adjustment Based on Renal Function: Dosing adjustment should be based on creatinine clearance (Cl_{cr}), as indicated in Table 1.

Pregabalin is effectively removed from plasma by hemodialysis. Over a 4-hour hemodialysis treatment, plasma pregabalin concentrations are reduced by approximately 50%. For patients receiving hemodialysis, pregabalin daily dose should be adjusted based on renal function. In addition to the daily dose adjustment, a supplemental dose should be given immediately following every 4-hour hemodialysis treatment (see Table below).

Table 1. Pregabalin Dosage Adjustment Based on Renal Function

Creatinine Clearance (Cl_{cr}) (mL/min)	Total Pregabalin Daily Dose (mg/day)[a] Recommended Dose Escalation*			Dose Regimen
	Starting dose		Maximum daily dose	
≥60	150	300	600	BID or TID
30-60	75	150	300	BID or TID
15-30	25-50	75	150	QD or BID
<15	25	25-50	75	QD
Supplementary dosage following hemodialysis (mg)[b]				
Patients on the 25 mg QD regimen: take one supplemental dose of 25 mg or 50 mg Patients on the 25-50 mg QD regimen: take one supplemental dose of 50 mg or 75 mg Patients on the 75 mg QD regimen: take one supplemental dose of 100 mg or 150 mg				

TID = Three divided doses; BID = Two divided doses; QD = Single daily dose.
* Based on individual patient response and tolerability.
a Total daily dose (mg/day) should be divided as indicated by dose regimen to provide mg/dose.
b Supplementary dose is a single additional dose.

OVERDOSAGE

Signs, Symptoms and Laboratory Findings of Acute Overdosage in Humans: The highest known dose of pregabalin received in the clinical development program was 15,000 mg in 1 patient. The types of adverse events experienced by patients who received an overdose were not clinically different from other patients receiving recommended doses of pregabalin.

Treatment or Management of Overdose: There is no specific antidote for overdose with pregabalin. If indicated, elimination of unabsorbed drug may be attempted by emesis or gastric lavage; usual precautions should be observed to maintain the airway. General supportive care of the patient is indicated including monitoring of vital signs and observation of the clinical status of the patient. A Certified Poison Control Center should be contacted for up-to-date information on the management of overdose with pregabalin.

Hemodialysis: Standard hemodialysis procedures result in significant clearance of pregabalin (approximately 50% in 4 hours) and should be considered in cases of overdose. Although hemodialysis has not been performed in the few known cases of overdose, it may be indicated by the patient's clinical state or in patients with significant renal impairment.

AVAILABILITY OF DOSAGE FORMS

LYRICA is available in dosage strengths of 25 mg, 50 mg, 75 mg, 100 mg,* 150 mg, 200 mg,* 225 mg,* and 300 mg capsules.

* Not commercially available in Canada

For a copy of the Product Monograph or full Prescribing Information, please contact: Pfizer Canada Medical Information at 1-800-463-6001 or visit www.pfizer.ca.

Pfizer

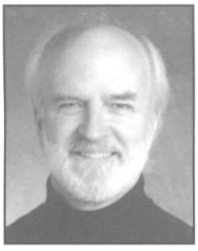
Working together for a healthier world™

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

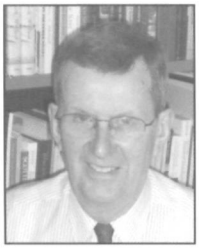
CANADIAN NEUROLOGICAL SCIENCES FEDERATION
FÉDÉRATION DES SCIENCES NEUROLOGIQUES DU CANADA

The Canadian Neurological Sciences Federation (CNSF) and Neurological Sciences Foundation of Canada (NSFC)

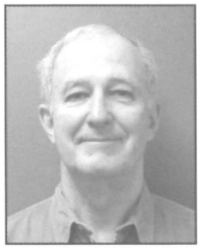
2008 – 2009 Board of Directors and Committee Chairs



George Elleker
- *CNSF President*
- *NSFC President*
- *CSCN Past President*



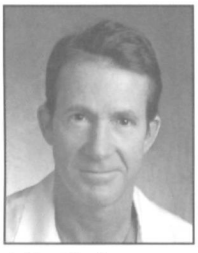
Garth Bray
- *CNSF Vice-President*
- *NSFC Vice-President*
- *CNS Member*



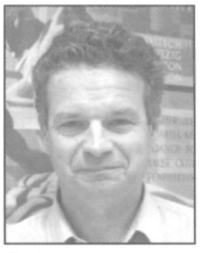
Derek Fewer
- *CNSF Vice-President*
- *NSFC Vice-President*
- *CNSS Past President*

Jerome Yager
- *CNSF Board Member*
- *NSFC Board Member*
- *CACN President*

Mary Connolly
- *CNSF Board Member*
- *NSFC Board Member*
- *CACN Vice-President*

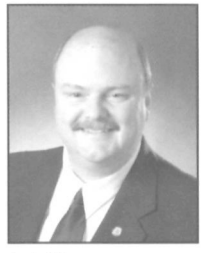


J. Max Findlay
- *CNSF Board Member*
- *NSFC Board Member*
- *CNSS President*



Chris Wallace
- *CNSF Board Member*
- *NSFC Board Member*
- *CNSS Vice-President*

Richard Desbiens
- *CNSF Board Member*
- *NSFC Board Member*
- *CNS President*



Lyle Weston
- *CNSF Board Member*
- *NSFC Board Member*
- *CNS Vice- President*

Manouchehr Javidan
- *CNSF Board Member*
- *NSFC Board Member*
- *CSCN President*

Ming Chan
- *CNSF Board Member*
- *NSFC Board Member*
- *CSCN Vice-President*

Teneille Gofton
- *CNSF Board Member*
- *NSFC Board Member*
- *Residents' Rep. CNS*

Gregory Hawryluk
- *Residents' Rep. CNSS*

Vijay Ramaswamy
- *Residents' Rep. CACN*

Andrew Kirk
- *CNSF/NSFC Past President*
- *Non-voting*

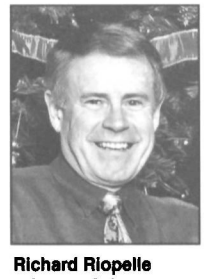
Dan Morin
- *CEO*

Non-voting

G. Bryan Young
- *Journal Editor-in-chief*
- *CNS & CSCN Member*

Mike Tymianski
- *CNSF Scientific Program Committee Chair*
- *CNSS Member*

Brian Wheelock
- *CNSF Professional Development Committee Chair*
- *CNSS Member*



Richard Riopelle
- *CBANHC Chair*

Legend:
CNSF - *Canadian Neurological Sciences Federation;* NSFC - *Neurological Sciences Foundation of Canada;* CNS - *Canadian Neurological Society;* CNSS - *Canadian Neurosurgical Society;* CSCN - *Canadian Society of Clinical Neurophysiologists;* CACN - *Canadian Association of Child Neurology;* CBANHC - *Canadian Brain and Nerve Health Coalition*

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

Canadian Neurological Sciences Federation 44th Annual Congress
Preliminary Program (Tentative) – as at November 20th, 2008

Tuesday, June 9/09

7:15 – 8:30	Residents' Breakfast
8:30 - 5:00	ALS
8:00 - 5:00	Advances in the Neurobiology of Disease ***Chairs: Peter Dirks and Peter Smith***
8:30 - 5:00	Child Neurology Day ***Chairs: Harvey Sarnat and Joe Dooley***
12:00 - 1:30	Lunch
6:00 - 8:00	Epilepsy Video Session ***Chair: Richard McLachlan***
6:00 - 8:00	Movement Disorders SIG ***Chair – Alex Rajput***
6:00 - 8:00	Headache SIG ***Chair TBC – Marek Gawel/Werner Becker***
6:00 - 8:00	Neuromuscular SIG ***Chair – Kristine Chapman***

Wednesday, June 10/09

8:00 - 10:00	Grand Opening Plenary-Scientific & Technical Advances in the Clinical Neurosciences: ***Cornelius Tulleken / Mark Bernstein / Ivar Mendez***
10:00 - 10:15	Coffee Break
10:15 - 11:45	Chair's Select Plenary Presentations
12:00 - 1:30	Co-developed Industry Symposium
12:00 - 1:30	Co-developed Industry Symposium
1:30 - 5:00	Neuroradiology ***Chair: Timo Krings***
1:30 - 5:00	Spine ***Chair: Eric Massicotte***
1:30 - 5:00	Medical and Surgical Stroke Prevention ***Chair: Max Findlay & Gord Gubitz***
1:30 - 5:00	Neurocritical Care ***Chair: Jeanne Teitelbaum***
1:30 - 5:00	Epilepsy ***Chairs: Francois Dubeau***
1:30 - 5:00	EMG ***Chairs: Ian Grant and Timothy Benstead***
1:30 - 5:00	Neuro-ophthalmology ***Chair: William Fletcher***
5:00 – 6:30	Opening of Exhibits Reception
6:30 – 8:00	Co-developed Industry Symposium
6:30 – 8:00	Co-developed Industry Symposium

Thursday, June 11/09

8:00 - 9:30	Plenary-CNS, CACN, & CSCN Neurology ***Michael Sinnreich / Brenda Banwell***
8:00 - 9:30	Plenary-CNSS Neurosurgery ***Michael West / Gary Steinberg***
9:30 -10:00	Coffee Break
10:00 - 12:15	Platforms (7 simultaneous)
12:15 - 2:00	Lunch/Exhibit Viewing/Digital Mini-platforms
2:00 - 4:30	Platforms (7 simultaneous)
4:30 - 5:30	Digital Poster and Exhibit Viewing
6:00 - 8:00	Presidents' Social

Friday, June 12/09

8:00 - 9:00	Distinguished guest lecture
9:00 - 9:15	Journal Editor's Report
9:15 - 9:30	CBANHC Report
9:30 - 10:15	Coffee break/Exhibit viewing
10:15 - 12:00	Grand Rounds
12:00 - 1:30	Lunch / Exhibit viewing / Digital Mini-platforms
1:30 - 5:00	Peripheral Nerve ***Chair: Raj Midha***
1:30 - 5:00	What's New in Neurosurgery? ***Chair: Ian Fleetwood***
1:30 - 5:00	EEG ***Chair: Seyed Mirsattari***
1:30 - 5:00	Endoscopy ***Chair: Mark Hamilton***
1:30 - 5:00	Dementia ***Chair: Sultan Darvesh***
1:30 - 5:00	What's New in Neurology? ***Chair: Roger McKelvey***
1:30 - 5:00	MS ***Chair: Virender Bhan***

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

It's a detour which led to an international award-winning, variable Twin Turbo diesel engine. It led to an astounding 425 lb-ft of torque the instant you press the accelerator. It led to more than 180 extra kilometres of legendary BMW performance per tank. Introducing clean, quiet BMW Advanced Diesel with BluePerformance, arriving soon in the new BMW 3 Series Sedan and X5 Sports Activity Vehicle. Welcome to our diesel detour – be the first to test drive at your local Calgary area BMW Retailer.

BMW Calgary Retailers

www.calgary retailers.bmw.ca

The Ultimate Driving Experience.®

In 1898, Rudolf Diesel patented it. In 2008, we took a detour.

BMW EfficientDynamics
Less emissions. More driving pleasure.

BMW Gallery
650 Crowfoot Crescent NW
Calgary, AB
403.275.6492
www.gallery.bmw.ca

Calgary BMW
34 Heritage Meadows Road SE
Calgary, AB
403.253.0338
www.calgary.bmw.ca

https://doi.org/10.1017/S0317167100117421 Published online by Cambridge University Press

LYRICA may be useful in the management of central neuropathic pain (NeP) in adult patients for which it has been issued marketing authorization with conditions to reflect the promising nature of the clinical evidence and the need for a confirmatory study to verify its clinical benefit. Patients should be advised of the nature of the authorization.

NEW

Pregabalin: First and only first-line analgesic with a conditional indication in central neuropathic pain

Pr LYRICA®

Powerful Pain Relief

Powerful. Fast onset. Sustained relief.

- Pain relief shown in postherpetic neuralgia (PHN) and central NeP as early as week 1 and demonstrated over 3 months[1-3*†]
- Improvement shown in pain-related sleep interference in PHN and central NeP as early as week 1 and demonstrated over 3 months[1-4*†]

Significant improvement in overall status.

- Significant improvement demonstrated in patient-reported overall status (Patient Global Impression of Change [PGIC]) in patients with peripheral NeP [diabetic peripheral neuropathy (DPN) or PHN] and central NeP[1-3,5*†‡]

LYRICA (pregabalin) is an analgesic indicated for the management of neuropathic pain (NeP) associated with DPN and PHN.

LYRICA is contraindicated in patients who are hypersensitive to pregabalin or to any ingredient in the formulation or component of the container.

The most commonly observed adverse events (≥5% and twice the rate as that seen with placebo) were dose related for PHN and DPN patients in the recommended dose range of 150 mg/day to 600 mg/day: dizziness (9.0-37.0%), somnolence (6.1-24.7%), peripheral edema (6.1-16.2%), and dry mouth (1.9-14.9%). The most commonly observed adverse events seen in central NeP patients (≥5% and twice the rate as that seen with placebo) in the recommended dose range of 150 mg/day to 600 mg/day were: somnolence (41.4%), dizziness (24.3%), asthenia (15.7%), dry mouth (15.7%), edema (12.9%), constipation (12.9%), amnesia (10.0%), myasthenia (8.6%), amblyopia (8.6%), and thinking abnormal (8.6%). The most commonly observed adverse events in the PHN, DPN, and central NeP patients were usually mild to moderate in intensity. Discontinuation rates due to adverse events for LYRICA and placebo, respectively, were 9% and 4% in DPN, 14% and 7% in PHN and 21% and 13% in central NeP.

Dosage reduction is required in patients with renal impairment (creatinine clearance <60 mL/min) as LYRICA is primarily eliminated by renal excretion.

Please see Prescribing Information for complete Warnings and Precautions, Adverse Reactions, Dosage and Administration and patient selection criteria.

* A 13-week, multicentre, double-blind, placebo-controlled trial in 368 patients with PHN. A significant difference in pain reduction was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day ($p \leq 0.01$, weeks 1-13). Sleep interference was improved at all time points (weeks 1 to 13 and endpoint) for the three doses evaluated ($p \leq 0.01$ vs. placebo). PGIC was reported as (at least minimally) improved by 51.2%, 47.9% and 67.1% of patients treated with LYRICA doses of 150, 300, and 600 mg/day vs. 35.5% of patients in the placebo group. At study termination, patients in the 150 mg/day ($p=0.02$) and 600 mg/day group ($p=0.003$) were more likely to report global improvement than those in the placebo group.

† Data based on a 12-week, parallel-group, double-blind, flexible-dose, placebo-controlled study. 137 patients with spinal cord injury for ≥1 year and who had a pain score ≥40 mm on the 100-mm visual analog scale (VAS) of the Short-Form-McGill Pain Questionnaire (SF-MPQ) were randomized to LYRICA 150 to 600 mg/day (n=70) or placebo (n=67) BID. Pain scores rated on 11-point numerical scale from 0 (no pain) to 10 (worst possible pain) during the past 24 hours averaged over the last seven days. Pain-related sleep interference scores rated on 11-point numerical scale from 0 (did not interfere) to 10 (completely interferes) during the past 24 hours averaged over the last seven days. A significant difference in pain reduction was demonstrated for the LYRICA group vs. placebo at all time points evaluated ($p \leq 0.001$, weeks 1-7 and endpoint and $p \leq 0.01$, weeks 8-12). Sleep interference was significantly improved at all time points (weeks 1 to 12 and endpoint) vs. placebo ($p \leq 0.01$, weeks 4, 10 and 12 and $p \leq 0.001$ for all other time points evaluated and endpoint). PGIC was reported as (at least minimally) improved by 56.5% and 21.5% of patients in the LYRICA and placebo treatment groups, respectively ($p<0.001$ for overall LYRICA comparison vs. placebo across "improved", "unchanged" and "worse" subgroups).

‡ A 12-week, multicentre, randomized, double-blind, placebo-controlled study in 338 patients with neuropathic pain (DPN [n=249] or PHN [n=89]), resulting in a significant difference from placebo in the flexible dose range 150-600 mg/day ($p \leq 0.05$, week 2-3 and $p \leq 0.01$, weeks 4-12), and the fixed dose of 600 mg/day ($p \leq 0.05$, week 1 and $p \leq 0.01$, weeks 2-12). PGIC was reported as very much improved or much improved by 52.0% of the flexible-dose group, 53.6% of the fixed-dose group and 30.5% of the placebo group ($p<0.01$ for overall comparison of both LYRICA treatment groups vs. placebo across "improved", "unchanged" and "worse" subgroups).

References: 1. Data on file, Pfizer Canada Inc., Study 1008-196. **2.** van Seventer R, Feister HA, Young JP *et al.* Efficacy and tolerability of twice-daily pregabalin for treating pain and related sleep interference in postherpetic neuralgia: a 13-week, randomized trial. *Curr Med Res Opin* 2006; 22(2):375-84. **3.** Siddall PJ *et al.* Pregabalin in central neuropathic pain associated with spinal cord injury: a placebo-controlled trial. *Neurology* 2006; 67:1792-800. **4.** LYRICA Product Monograph, Pfizer Canada Inc., November 8, 2007. **5.** Freynhagen R, Strojek K, Griesing T *et al.* Efficacy of pregabalin in neuropathic pain evaluated in a 12-week, randomised, double-blind, multicentre, placebo-controlled trial of flexible- and fixed-dose regimens. *Pain* 2005; 115:254-63.

Pfizer
Working for a healthier world™

PAAB Member R&D

Pr LYRICA® PREGABALIN

Fast onset. Sustained relief.

See prescribing summary A-9, A-10